# Referral to Medicaid Case Management

Humana®

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| **Patient name:**<br>**Patient address:** | | | **Humana ID:** | **Pharmacy:** | |
| **Phone:** | **DOB:** | **Plan:** | **Effective date:** | **Type of referral:**<br>Routine Urgent | |
| **POA:** | **Relationship:** | | **Home phone:** | **Cell phone:** | |
| **Family member name(s):** | **Relationship:** | | **Home phone:** | **Cell phone:** | |
| **Person making the referral:** | | | **Phone:** | | |
| **Patient's PCP:** | **PCP address/office phone/fax:** | | | **PCP email:** | |
| **Referring patient to:** | **Case management ____ Disease management ____ Moms First: _____** | | | | |
| **Demographics (include level of function, living arrangements, transportation, challenges for patient, etc.):** | | | | | |
| **Problem list:** | | | | | |
| **Hospitalizations (include date and name of hospital):** | | | | | |
| **Procedures/surgeries:** | | | | | |
| **HEDIS® measures:** | | | | | |
| **Medications:** | | | | | |
| **Other:** | | | | | |

**Please fax completed form to 1-833-939-1312 or send via email to:**
KYMCDCaseManagement@humana.com

**Toll-free case and disease management telephone: 1-888-285-1121**